

MDR Tracking Number: M5-04-1813-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 2-20-04.

The IRO reviewed joint mobilization, therapeutic procedures one or more areas each 15 minutes, manual traction, and therapeutic procedures rendered from 4-8-03 to 4-10-03 that were denied based upon “U”.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that joint mobilization (97265) and manual traction (97122) were not medically necessary. The IRO concluded that therapeutic procedures (97110) were medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$175.00). Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 6, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified below. The requestor submitted convincing evidence that supports bills were submitted for audit. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

The insurance carrier indicated on the EOBs that payment per *Medical Fee Guideline* was recommended for services identified with EOB code "F." The Medical Review Division contacted the requestor on 1-13-05 to verify that payment had been made; however, the requestor's representative, Carol, was not available and message was left. At the time of review, a return call from Carol had not been received. The respondent did not support canceled check to support payment was made. These services will be reviewed in accordance with the *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
3-10-03	99214	\$75.00	\$0.00	No EOB	\$71.00	CPT Code Descriptor	MAR reimbursement of \$71.00 is recommended.
3-13-03 3-14-03 3-17-03 3-24-03 3-27-03 4-1-03 4-15-03 4-26-03 4-29-03 5-1-03 5-6-03 5-8-03 5-15-03 5-20-03 5-22-03 5-27-03 5-29-03 6-3-03 6-5-03 6-12-03 6-17-03 7-24-03	99213MP	\$50.00	\$0.00	F	\$48.00	CPT Code Descriptor	MAR reimbursement of \$48.00 X 22 dates= \$1,056.00 is recommended.
3-13-03 4-26-03 5-15-03	99354	\$110.00	\$0.00	F	\$106.00	CPT Code Descriptor	MAR reimbursement of \$106.00 X 3 dates= \$318.00 is recommended.
3-13-03 3-14-03 3-17-03 3-24-03 3-27-03 4-1-03 4-15-03 4-26-03 4-29-03 5-1-03 5-6-03 5-8-03 5-15-03 5-20-03 5-22-03 5-27-03	97265	\$45.00	\$0.00	F	\$43.00	CPT Code Descriptor	MAR reimbursement of \$43.00 X 22 dates= \$946.00 is recommended.

5-29-03 6-3-03 6-5-03 6-12-03 6-17-03 7-24-03							
3-13-03 4-26-03 4-29-03 5-1-03 5-6-03 5-8-03 5-15-03 5-20-03 5-27-03 5-29-03 6-3-03 6-5-03 6-12-03 6-17-03 7-24-03	97110	\$35.00	\$0.00	F	\$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	See Rationale Below
3-14-03 3-27-03 4-1-03	97110(2)	\$70.00	\$0.00	F	\$35.00 / 15 min X 2 = \$70.00		
3-17-03	97110(3)	\$105.00	\$0.00	F	\$35.00 / 15 min X 3 = \$105.00		
3-24-03	97110(4)	\$140.00	\$0.00	F	\$35.00 / 15 min X 4 = \$140.00		
3-13-03 3-14-03 3-17-03 3-24-03 3-27-03 4-1-03 4-15-03 4-26-03 4-29-03 5-1-03 5-6-03 5-15-03 5-20-03 5-22-03 5-27-03 5-29-03 6-3-03 6-5-03 6-12-03 6-17-03 7-24-03	97122	\$35.00	\$0.00	F	\$35.00 / 15 min	CPT Code Descriptor	MAR reimbursement of \$35.00 X 21 dates= \$735.00 is recommended.
3-13-03 3-14-03 3-17-03 3-24-03 3-27-03 4-1-03 4-26-03	97139EU	\$65.00	\$0.00	N	DOP	General Instructions GR (III) MGR (I)(C)(1)(k)	Documentation does not meet DOP requirements, reimbursement is not recommended.

4-29-03							
4-15-03 5-1-03 5-6-03 5-8-03 5-15-03 6-17-03 7-24-03	97014	\$20.00	\$0.00	F	\$15.00	CPT Code Descriptor	MAR reimbursement of \$15.00 X 7 dates= \$105.00 is recommended.
4-15-03 5-20-03 5-22-03 5-27-03 5-29-03 6-3-03 6-5-03 6-12-03	97035	\$25.00	\$0.00	F	\$22.00	CPT Code Descriptor	MAR reimbursement of \$22.00 X 8 dates= \$176.00 is recommended.
4-30-03	99214	\$75.00	\$0.00	F	\$71.00	CPT Code Descriptor	MAR reimbursement of \$71.00 is recommended.
5-6-03 5-8-03 6-5-03 7-5-03 7-24-03	99080-73	\$15.00	\$0.00	F	\$15.00	Rule 129.5(d)	There was no change in claimant's work status to support billing for TWCC-73s; therefore, no reimbursement is recommended.
5-9-03 6-19-03	99090	\$110.00	\$0.00	No EOB	\$108.00	CPT Code Descriptor	MAR reimbursement of \$108.00 X 2 dates= \$116.00 is recommended.
5-13-03 7-5-03 7-7-03	99213MP	\$50.00	\$0.00	No EOB	\$48.00	CPT Code Descriptor	MAR reimbursement of \$48.00 X 3 dates= \$144.00 is recommended.
5-13-03	97014	\$20.00	\$0.00	No EOB	\$15.00	CPT Code Descriptor	MAR reimbursement of \$15.00 is recommended.
5-13-03 7-5-03 7-7-03	97122	\$35.00	\$0.00	No EOB	\$35.00 / 15 min	CPT Code Descriptor	MAR reimbursement of \$35.00 X 3 dates= \$105.00 is recommended.
5-13-03 7-5-03 7-7-03	97265	\$45.00	\$0.00	No EOB	\$43.00	CPT Code Descriptor	MAR reimbursement of \$43.00 X 3 dates= \$129.00 is recommended.
5-13-03 5-22-03	97110	\$35.00	\$0.00	No EOB	\$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	See Rationale Below
5-15-03 7-5-03	99354	\$110.00	\$0.00	No EOB	\$106.00	CPT Code Descriptor	MAR reimbursement of \$106.00 X 2 dates= \$212.00 is recommended.
8-11-03	99455VR	\$50.00	\$0.00	F	\$50.00	CPT Code Descriptor	MAR reimbursement of \$50.00 is recommended.
8-19-03	99090	\$110.00	\$0.00	F	NRF		
9-15-03	99080 (161)	\$120.75	\$0.00	F	\$0.50/ pg	Rule 133.106	MAR reimbursement of \$80.50 is recommended.
TOTAL							The requestor is entitled to reimbursement of \$4329.50

Rationale for 97110:

Recent review of disputes involving one-on-one CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit documentation to support reimbursement in accordance with the 1996 MFG and 133.307(g)(3). Therefore, reimbursement is not recommended.

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 3-10-03 through 9-15-03 in this dispute.

This Order is hereby issued this 19th day of January 2005.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

May 13, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT Corrected dates of service in dispute.

Re: Medical Dispute Resolution
MDR #: M5-04-1813-01

TWCC#:
Injured Employee:

DOI:
SS#:
IRO Certificate No.:

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services and EOB's
Chiropractic initial exam on 01/08/03
Foot & Ankle surgeon's reports – 02/11/03 thru 08/11/03
S.O.A.P. Notes – 01/08/03 thru 06/27/03
ROM 01/28/03 and FCE 10/02/03
Operative report 02/20/03, MRI 02/07/03, X-ray 01/07/03

Clinical History:

The records indicate the patient injured her left knee while working on ___. She has been plagued since that time with medial joint pain, catching, popping, and instability. She went through 2 months of physical therapy and had been on a course of Vioxx. An MRI performed on 02/07/03 documented a medial meniscus tear and probable patellar chondral tearing. Over the course of this patient's treatment, she received passive care with progression into active care. Her condition responded minimally to conservative treatment, and surgical intervention on 2/20/03 was necessary. Surgical intervention was completed, and an aggressive post-surgical rehabilitation program was ordered by her surgeon.

Disputed Services:

Joint mobilization, therapeutic procedures one or more areas each 15 minutes, manual traction, and therapeutic procedures during the period of 04/08/03 through 04/10/03.

Decision:

The reviewer partially agrees with the determination of the insurance carrier and is of the opinion that joint mobilization and manual traction was not medically necessary.

Therapeutic procedure one or more areas each 15 minutes, and therapeutic procedure during the stated period were medically necessary in this case.

Rationale:

National Treatment Guidelines allow for this type of treatment in this type of injury. Initially, conservative care produced only limited results. As mentioned above, her condition required surgical intervention with postoperative rehabilitation. Based upon the documentation provided, it was not medically necessary for this patient to receive joint mobilization or manual traction during the period of 3/10/03 through 09/15/03. However, it was, in fact, reasonable, usual, customary, and medically necessary for the patient to receive postoperative rehabilitation in the form of therapeutic procedure 1 or more areas each 15 minutes and therapeutic procedure during the 03/10/03 through 09/15/03.

Sincerely,